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ASSISTED OUTPATIENT TREATMENT
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No Relevance to Assisted Outpatient Treatment (AOT) in the OCTET Study of English Compulsory Treatment

SUMMARY

The Oxford Community Treatment Order Evaluation Trial (OCTET) compared hospital re-admission rates between two randomized groups of psychiatric outpatients in England. Both groups received intensive compulsory community supervision upon hospital discharge but under two different English legal mechanisms: one group subject to the traditional "extended leave of absence" and the other to the relatively new option of a "community treatment order" (CTO). The study found no difference in subsequent hospital re-admissions between the two groups, despite the CTO patients receiving mandated care for significantly longer periods.

Some have suggested the OCTET findings, published in *The Lancet* in 2013, raise questions about court-ordered "assisted outpatient treatment" (AOT), an American treatment option that has *no British equivalent* and has been reported in multiple studies to vastly improve treatment outcomes. While the OCTET study offers an instructive comparison of two English forms of mandated treatment, it adds nothing to the body of knowledge on the American AOT model, much less to the question of whether AOT offers benefits over voluntary treatment.

Burns, T., Rugkasa, J., Molodynski, A., Dawson, J., yeeles, K., Vazquez-Montes, M., Voysey, M., Sinclair, J., Priebe, S. (2013). Community treatment orders for patients with psychosis (OCTET): a randomized controlled trial. *The Lancet*, *381,* 1627–1633.

NEITHER FORM OF MANDATED TREATMENT CONSIDERED IN THE OCTET STUDY IS EQUIVALENT TO THE AMERICAN AOT MODEL.

In certifying AOT as a proven best practice to reduce crime, the US Department of Justice defined AOT as "a civil legal procedure whereby *a judge* can order an individual with a serious mental illness to follow a *court-ordered* treatment plan in the community" (emphasis added). This is consistent with how AOT has always been understood in the United States.

The English CTO is a purely administrative order issued by a clinician, not a judge, and as such does not qualify as AOT. This is no mere technical distinction. The court order is essential to the AOT model because the "black-robe effect" is regarded by AOT proponents as a powerful part of why it works.

The theory behind the black-robe effect is that a judicial process and a judge's imprimatur increase the likelihood that the patient will take to heart the need to adhere to prescribed treatment. It is not a single factor but a host of related ones that combine to send a potent message: the ritual of being summoned to court and taking part in a hearing, the recognition that a fair-minded third party has listened to both sides and ultimately agreed with clinicians that assisted treatment is warranted, the cultural perception of the judge as an authority figure, and the inclination of many judges to use their bench as a sort of civic pulpit.

While the existence of a black-robe effect in AOT has yet to be the subject of empirical study, it is clear that confidence in it has been central to the pro-AOT argument in the US. It is simply unfair to draw conclusions about AOT from a study of a treatment model in which the court plays no role at all.

As further noted below, studies of actual AOT have resoundingly found that it improves treatment outcomes for its target population.

National Institute of Justice. (2012). *Program profile: Assisted outpatient treatment (AOT).*

Treatment Advocacy Center. (2011). *Stopping the revolving door[Documentary].*

THE OCTET STUDY COMPARES TWO SIMILAR FORMS OF MANDATED TREATMENT TO ONE ANOTHER.

It does not compare outcomes of mandated treatment to outcomes of voluntary treatment.

In contrast to the AOT studies discussed below, *the OCTET study does not offer a comparison between mandated and voluntary treatment for high-risk patients.* With respect to the two involuntary treatment mechanisms subjected to study, the OCTET authors acknowledge that "it is unclear whether either regime is more restrictive than the other."

In terms of the burden placed on patient freedom, the only measure by which the CTO appears more onerous than the leave of absence is the length of time for which it tends to be utilized. While the English law authorizing leave of absence does allow for long (and even indefinite) terms, the study authors report this has not been the typical practice in the years since the CTO became an alternative option.

UK Dept. of Health, Code of Practice, Mental Health Act 1983 (Rev. 2008), § 21.7.

THE OCTET STUDY ONLY CONSIDERS THE EFFECTIVENESS OF CTOS MAINTAINED FOR LESS THAN SIX MONTHS.

Even assuming equivalence between CTOs and AOT orders, six months would be insufficient time to fully assess the effectiveness of AOT.

The most significant finding of the OCTET study is that the patients in one group who spent an average of 170 days under CTOs did no better in avoiding re-admission than the patients in the other group who spent an average of 45 days under leave of absence. At most, this suggests that a short period of mandated treatment is no more effective than an even shorter period of mandated treatment. It does *not* logically follow from this that a one-year period of mandated treatment would also prove no more effective than the 45-day period did.

And in fact, in the AOT context, research strongly suggests that the typical period necessary for the treatment mandate to reach full impact is greater than six months. A study performed in North Carolina, published in *Psychiatric Services* in 2001, found that patients who received AOT for more than six months were admitted to hospitals less than half as often as control-group (non-AOT) patients, whereas those who received AOT for less than six months had hospital admission rates comparable to the control group. Similarly, a 2009 independent

evaluation of New York's AOT program found that AOT of six months or more had a greater impact than did shorter-term AOT on the likelihood that outcome improvements would be sustained after AOT ends. It is therefore critical to keep in mind the very short periods of mandated treatment considered in the OCTET study.

Swartz, M.S., Swanson, J.W., Hiday, V.A., Wagner, H.R., Burns, B.J., Borum, R. (2001). A randomized control trial of outpatient commitment in North Carolina. *Psychiatric Services, 52(3),* 325—329.

Swartz, M.S., Swanson, J.W., Steadman, H.J., Robbins, P.C., Monahan, J. (2009). New York state assisted outpatient treatment program evaluation, *New York State Office of Mental Health.*

THE OCTET STUDY IS LIKELY BASED ON FLAWED RANDOMIZED SAMPLING.

The study likely includes many patients who did not need mandated treatment and excludes many of those who needed it most.

Advocates for mandated treatment routinely stress that it is appropriate only for a small subset of people with chronic mental illness. Involuntary methods are designed to help those who have demonstrated an inability to access voluntary services (usually due to lack of insight). No responsible advocate would suggest that the majority of people with severe mental illness stand to benefit from mandates.

From an American perspective, the English CTO law is most striking for the vagueness and subjectivity of its eligibility criteria and its omission of judicial oversight. Consequently, it is not surprising to learn that the UK's Care Quality Commission has expressed alarm over the number of people who have been placed under CTO since the law's inception. The Commission reports that on average, 367 CTOs have been imposed each month – roughly 10 times the number anticipated when the law was introduced. This prompted the Commission to examine a sample of 200 people placed under CTO and find that roughly 30 percent had no history of non-compliance or disengagement from treatment. It is thus hard to disregard the likelihood that the OCTET's initial sample of 336 randomized patients included a great many individuals who would never have been found in need of AOT in an American court.

Worse yet, there is reason to worry that many of the patients who stood to benefit the *most* from mandated treatment were disqualified prior to randomization. The study authors reveal two very significant instances of self-selection bias in their sampling. Their initial sample excluded patients whose families felt strongly about the need for longer supervision and, unwilling to face the 50 percent risk that their loved ones would be assigned to the leave-of-absence group, self-selected out of the study. Moreover, of 427 patients deemed eligible for the study, 91 (21 percent) declined to participate in their initial interviews and were excluded from the randomized sample. It is reasonable to expect significant overlap between the patients least willing to participate in a study of supervised treatment and those least likely to voluntarily follow their treatment plans (i.e., the small group to whom American AOT programs are typically tailored). If in fact there were significant qualitative differences between the patients who were ruled out or refused to join the study and those who participated, the randomized sample would show an overrepresentation of individuals who would never qualify as AOT candidates in the US.

Torrey, E.F. (2013, April 28). Forcing mentally ill patients into treatment. *Roanoke Times.*
MHA 1983 s17A. See paragraph (5).

Williams, J. (2010, October 27). Are community treatment orders being overused? *The Guardian*.

MULTIPLE STUDIES HAVE VALIDATED THE EFFICACY OF AOT.

While the OCTET study sheds no light on the utility of AOT in helping high-risk psychiatric outpatients avoid hospitalization, multiple US studies have linked AOT to sharp declines in readmissions and/or hospital days. The OCTET authors fail to mention most of these studies in their brief review of the prior literature, apparently because they categorically and imprudently dismiss studies not based on randomized controlled trials. Most studies of AOT consider a single group of patients, contrasting outcomes observed prior to and during (and in some cases post-) AOT. Randomized controlled trials are rarely conducted in non-pharmacological studies of psychiatric treatment because they are expensive and present ethical challenges. To study AOT in this manner would require establishing a control group of AOT-eligible, insight-deficient, severely mentally ill "revolving door" outpatients and permitting them to decide for themselves whether to engage in the treatment offered. It is fair to presume that family objections to having loved ones assigned to the control group – which the OCTET authors encountered when offering a choice between two forms of *mandated* treatment – would be near universal.

While AOT has rarely been studied with randomized controls, the existing observational research has strong empirical validity due to the large cumulative sample size. Over decades these studies have consistently and repeatedly found that AOT reduces the need for psychiatric hospitalization. Most notably, and in stark contrast to what is feasible in a randomized controlled trial, the 2009 evaluation of AOT in New York based this conclusion on the tracking of more than 3000 AOT recipients in six disparate counties over an eight-year period. At some point -- far behind us, wherever it may lie – the significance of such findings becomes undeniable.

Zanni, G. & deVeau, L. (1986). Inpatient stays before and after outpatient commitment. *Hospital and Community Psychiatry, 37,* 941-942.

Munetz, M., Grande, T., Kleist, J., Peterson, G.A. (1996). The effectiveness of outpatient civil commitment. *Psychiatric Services*, 47, 1251-1253.

Rohland, B. (1998). The Role of Outpatient Commitment in the Management of Persons with Schizophrenia. Iowa City: Iowa Consortium for Mental Health, Services, Training, and Research.

Esposito, R., Westhead, V., Berko, J. (2008). Florida's outpatient commitment law: Effective but underused, *Psychiatric Services, 59*, 328.